Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2015	2015_178102_0022	O-001903-15 AND O-002017-15	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

Long-Term Care Home/Foyer de soins de longue durée

MAPLEWOOD
12 MAPLEWOOD AVENUE BOX 249 BRIGHTON ON K0K 1H0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 28 and 29, 2015

This inspection involved 2 Critical Incident Reports(CIR): Log # O-001903-15, CIR 2717-000010-15 related an emergency involving a gas fired hot water tank; and Log # O-002017-15, CIR 2717-000014-15 related to a municipal water shut down and subsequent boil water emergency.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director Care, the Maintenance person, several staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the gas fired hot water heaters/tanks are serviced at least annually. The last documented servicing of the gas fired hot water tanks was in September 2011.

CIR # 2717-000010-15 identifies that on March 17, 2015, staff of the home "detected a strong odour of gas from the laundry room". It was subsequently identified that the venting on 1 of 2 gas fired hot water tanks within the laundry room needed improvements and the tank was locked out/tagged out, gas shut off to the unit. On March 19, 2015 a contractor completed alterations to the venting and the operation of the tank was restored. [s. 90. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by developing and implementing procedures to ensure that the hot water tanks are serviced at least annually and that documentation of the service is kept, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (2) Every licensee of a long-term care home shall ensure that the emergency plans for the home are in writing. O. Reg. 79/10, s. 230 (2).

s. 230. (3) In developing the plans, the licensee shall,
(a) consult with the relevant community agencies, partner facilities and resources that will be involved in responding to the emergency; and O. Reg. 79/10, s. 230 (3).
(b) ensure that hazards and risks that may give rise to an emergency impacting the home are identified and assessed, whether the hazards and risks arise within the home or in the surrounding vicinity or community. O. Reg. 79/10, s. 230 (3).

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home. O. Reg. 79/10, s. 230 (4).

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
4. Identification of the community agencies, partner facilities and resources that will be involved in responding to the emergency. O. Reg. 79/10, s. 230 (4).

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Findings/Faits saillants :

1. The town of Brighton's municipal water supply was shut down for approximately 32 hours commencing April 17, 2015. A municipal "Boil Water Advisory" was implemented following restoration of the water supply. Critical Incident Report (CIR) # 2717-000014-15 was submitted regarding the municipal "state of emergency".

The licensee has failed to ensure that the emergency plan titled "Loss of Water Services" includes all of the required components in writing.

The licensee did not have an emergency plan in writing for dealing with the boil water advisory/contaminated or non potable water supply. [s. 230. (2)]

2. There is no indication within the emergency plan, that relevant community agencies involved in responding to a water emergency, have been consulted in the development of the emergency plan; for example:
- Public Health/Medical Officer of Health
- Municipal Emergency Planning official(s) [s. 230. (3)]

3. The emergency plan for the loss of water to the home, does not provide for resources, supplies and equipment vital for the response being set aside and readily available at the home. [s. 230. (4) 3.]

4. The licensee has failed to ensure that the emergency plan for the "Loss of Water Services" identifies community agencies and resources involved in responding to the emergency. Example: provision of water to the home, involvement of Public Health, Municipal Fire Department, etc. [s. 230. (4) 4.]

5. The licensee has failed to ensure that emergency plans address specific staff roles and responsibilities. Example: for loss of water service/contaminated water supply, housekeeping staff roles and responsibilities are not identified; nursing staff duties are not identified, etc. [s. 230. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that emergency plans for the home are in writing and are in compliance with all applicable requirements, to be implemented voluntarily.

Issued on this 20th day of May, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.